Name:_____ **Date:**_____ **DOB:**_____

Name of pharmacy _____ ***Location of pharmacy***_____

Last Medical History: (please circle all that apply)

Anxiety	Coronary Artery	Hypothyroidism
Asthma	Disease	Leukemia
Arthritis	Depression	Lung Cancer
Atrial fibrillation	Diabetes	Lymphoma
BPH	GERD	Prostate Cancer
Bone Marrow	Hearing Loss	Radiation Treatment
Transplantation	Hepatitis	Seizures
Breast Cancer	Hypertension	Stroke
Colon Cancer	HIV/AIDS	**None of these**
COPD	Hypercholesterolemia	**apply to me** _____

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Heart: transplant
Bladder Removed	Bladder Removed
Mastectomy: right – left - both	Kidney: nephrectomy/removal
Lumpectomy: right – left - both	Kidney: transplant
Breast Biopsy	Ovaries: cyst – cancer -endometriosis
Breast Reduction	Prostate: removal
Colon: colectomy, diverticulitis	Prostate: biopsy – TURP - cancer
Colon: inflammatory bowel disease	Skin: biopsy
Gallbladder removal/cholecystectomy	Spleen: removal
Heart: coronary artery bypass	Testicles: removal
Knee replacement: left – right – both	Uterus: fibroids - cancer
Hip replacement: left – right - both	**I have had no surgeries:**_____

Other _____

Skin Disease History: (please circle all that apply)

Acne	Eczema	Psoriasis
Actinic Keratoses	Flaking or Itchy Scalp	Squamous Cell Skin Cancer
Basal Cell Skin Cancer	Hay Fever/Allergies	**Other** _____
Blistering Sunburns	Melanoma	
Dry Skin	Poison Ivy	
	Precancerous Moles	

Do you wear Sunscreen? _____ ***What SPF?*** _____

Review of Systems: Please check what applies to you

Anger issues		New tender pimples	
Artificial heart valve		Night sweats	
Blood thinners		Pacemaker	
Bloody stool or toilet paper		Painful joints	
Defibrillator		Pimples on back of neck or scalp	
Dry crusty nose or blood with nose-blowing		Pregnancy or planning a pregnancy	
Dry eyes or blurry vision		Pre-medication prior to procedures	
Dry lips		Problems with healing	
Easy bleeding or bruising		Rapid heartbeat with dental anesthetic (epinephrine)	
Excessive periods		Scarring problems (hypertrophic or keloid)	
Fever or chills		Swelling of ankles	
GI upset with antibiotics		Symptom	
Immunosuppression		Tanning bed use	
Muscle weakness		Weight gain or loss	

FAMILY HISTORY

Adopted- Yes / No (Please Circle)

Disease	**Mother**	**Father**	**Sister**	**Brother**	**Son**	**Daughter**
Alcoholism/Drug abuse						
Alzheimers						
Asthma						
Autoimmune Disease						
Bleeding or Clotting Disorder						
Coronary Artery Disease						
Defibrillator						
Depression						
Diabetes						
Heart Disease						
Hepatitis B or C						
High Blood Pressure						
High Cholesterol						
History Melanoma						
Kidney Disease						
Migraine Headaches						
No significant history known						
Other (list)						
Pacemaker						
Seizures						
Thyroid problems						